



**PERSONAL HEALTH INFORMATION**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for visit today: \_\_\_\_\_

Any known drug allergies: \_\_\_\_ No \_\_\_\_ Yes If yes, please list: \_\_\_\_\_

**PATIENT INFORMATION PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S).**

Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Email Address: \_\_\_\_\_

Appointment Reminders: Select **ONE** of the methods below to receive your appointment reminders.

\_\_\_\_ Text Message \_\_\_\_ Email \_\_\_\_ Phone Call: \_\_\_\_ Home Phone \_\_\_\_ Cell Phone

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

**CURRENT MEDICATIONS**

<u>MEDICATION</u>	<u>DOSAGE</u>	<u>PRESCRIBING PHYSICIAN</u>

Have you had any surgeries since your last visit? \_\_\_\_\_

Have you had any changes in your medical history? \_\_\_\_\_

Date of last menstrual period (first day): \_\_\_\_\_

Current method of birth control: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ Physician / Clinic: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Facility: \_\_\_\_\_

Date of last colonoscopy: \_\_\_\_\_ Facility: \_\_\_\_\_